acts like a sling. Cystocele, therefore, is due to a descent of the upper support of the bladder—the uterus—and the yielding of the vaginal sheath, permitting a hernia of the bladder. An additional factor is sliding of the various planes of tissue composing the vesicovaginal septum. Based upon these conceptions of production, the author has devised operative procedures to meet the conditions presented. Briefly summarized, the operation for cystocele consists, first, in a free dissection of the bladder from its attachments. After suspending the uterus by shortening the ligaments, the bladder is restored to its normal position and held in place by three catgut sutures, one at its fundus and one at each cornu, thus spreading out and fixing the base of the bladder. After excising the excess of tissue, the fascial sheath and vaginal mucosa are sutured. In case of extreme procidentia, a vaginal hysterectomy is performed and the broad ligaments are sutured together across the pelvis, taking up all slack necessary to make them taut. Upon this support the bladder is spread and sutured, as previously mentioned. The upper end of the vagina is also attached to the broad ligaments after removing sufficient tissue to obtain the support of the fascia lata. In all cases in which a rectocele exists the perineum is repaired.

The Radical Cure of Hemorrhoids: Modified Whitehead's Operation.—By omitting dilatation of the sphincter, O'Conor (*Lancet*, 1910, clxxix, 946) has found that the operation for hemorrhoids can be easily performed in a short time with but little loss of blood. He emphasizes the importance of removing only the thin cuff of mucous membrane along with the loose areolar tissue which bears the hemorrhoidal veins, of carefully avoiding injury to the sphincter by using the senses of sight and touch, and not encroaching too much on the skin when making the primary circular incision. Four Lane's forceps are applied to the four cardinal points of the anal circle exactly at the mucocutaneous junction, irrespective of rugosities. With scissors each segment is divided at the mucodermal line until the circumference has been completed, the primary cut including skin and some subcutaneous tissue. The left index finger is inserted into the anal canal and the separation carried down to the submucosa; the external sphincter is pushed upward with a blunt dissector. No further advance must be made until the submucosa is well defined throughout the whole circumference, and the sphincter has been freed. During the process of freeing the mucosa, forceps are applied to its cut edge to serve as tractors. By blunt dissection the cuff is freed as high as the internal sphincter, which is indicated by the transverse fold of mucous membrane. A vertical slit is made in the mucosa up to this point and the apex sutured to the skin; the cuff is excised by a series of transverse cuts, uniting the mucosa and skin with a continuous catgut suture as the division progresses. Fibrous strictures resulted in 2 out of 450 cases thus treated; a partial recurrence occurred in one patient, who subsequently developed cirrhosis of the liver.

The Wertherim-Schauta Operation.—Based upon his experience in 40 cases, Stoeckel (*Archiv f. Gynäk.*, 1910, xci, 546) details the important points in operative technique as well as a few of the complications which he has observed during convalescence. The operation is used in cases of cystocele, and consists in the interposition of the uterus between the base of the bladder and the anterior vaginal wall. Of great importance is complete mobilization of the cystocele sack. Too frequently the bladder is separated from the anterior cervical wall only sufficiently to permit delivery of the uterus through the uterovesical fold of peritoneum, which produces an elevation of the centre of the cystocele, leaving unaltered a pouch on either side. Total recurrence is certain to follow, due to the constant traction exerted by these lateral recesses. Complete mobilization of the cystocele requires division of the so-called "bladder pillars," which consist of dense tissue extending from the base of the bladder to the anterior vaginal wall. To avoid hemorrhage, these ligaments should be divided between ligatures. Injury to the ureters will be obviated by incising the pillars transversely close to the vaginal wall at the lower angle of the colporrhaphy wound. Secondly, the uterus must be placed in such a position that it supports the whole bladder. Every uterus which is brought in the position of forced anteversion has the tendency to upright itself. Should this tendency be marked, the fundus will project into the bladder, leaving unsupported a portion anterior to it; or there may be a complete or partial separation of the uterus from its points of fixation. Should force be necessary to bring the uterus under the urethra, the interposition is contraindicated. When the uterus is too small to serve as a proper support, a broad base is obtained by suturing the round ligaments to the vaginal wall. Enlargement of the uterus due to chronic metritis is especially adaptable for this purpose. The cervix is amputated only when it forms a sharp angle with the body of the uterus. In every case the uterine cavity is examined by incising the anterior wall from the fundus to the internal os; after thorough cauterization, this incision is closed. As the last important point, Stoeckel urges that complete hemostasis be secured. Bladder symptoms of varying intensity frequently follow the operation. In one case dribbling of urine developed a few weeks after operation, due to a sacculation of the bladder immediately posterior to the urethra, which resulted from spontaneous elevation of the uterus; a second case, in which the bladder was accidentally opened, developed a stubborn cystitis, which was aggravated by the distortion of the bladder incident to operation. One death resulted from pulmonary embolism. The only disadvantages to this operation are the length of time necessary for its performance, and the increased disposition to thrombosis. Especial care is advisable in the presence of a demonstrable myocarditis.

The Structure of the Stroma of the Endometrium and its Bearing on the Menstrual Changes.—As the result of his studies, Young (*Brit. Med. Jour.*, 1910, ii, 1214) states the following conclusions: The stroma of the endometrium consists of a soft semifluid protoplasmic mass, imperfectly differentiated into cellular elements. The cells anastomose freely with one another by means of protoplasmic processes. They present many and varying alterations in shape, but these are easily dispelled, and the cells then approximate to the typical stellate shape. The differentiation of the stroma cells is thus probably more apparent than real. The intercellular spaces, in all probability, do not directly communicate with one another. The anastomosing processes